Exhibit B

CROSSROADS HEALTHCARE MANAGEMENT LLC

ADMINISTRATIVE SERVICE AGREEMENT

WITH THE

ALLIED WELFARE FUND

MARCH 2007

ADMINISTRATIVE SERVICE AGREEMENT

This AGREEMENT effective March 1, 2007, by and between the Board of Trustees of the Allied Welfare Fund (hereinafter referred to as the "Board") and Crossroads Healthcare Management LLC (hereinafter referred to as "Crossroads).

WHEREAS, the Allied Welfare Fund (hereinafter sometimes referred to as the "Fund" or the "Plan") is an employee welfare benefit plan established in accordance with the Employee Retirement Income Security Act of 1974, as amended from time to time and commonly known as "ERISA" as well as the applicable provisions of the Labor Management Act of 1947; and

WHEREAS, the Fund, under the direction and control of the Board, provides health and welfare benefits to eligible employees represented by the Allied Trades Council Division of Local 338 RWDSU/UFCW (hereinafter referred to as "ATC" or the "Union") and their eligible dependents (hereinafter referred to as "Covered Persons"); and

WHEREAS, the Board has requested that Crossroads perform certain independent administrative services as are more particularly described in this Agreement and Crossroads has, in turn, agreed to perform such services upon the terms and conditions hereinafter set forth.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, it is herby agreed as follows:

SECTION I – Services to be Performed by Crossroads.

1.1 Crossroads shall provide the Fund with all of the services and administrative duties as are set forth and described in Exhibit "A" with the intent being to assist the Board in carrying out and fulfilling its employee welfare and benefit plan obligations.

1.2 While Crossroads is authorized, under this Agreement, to do all acts, which are deemed necessary or convenient to carry out the terms and purposes of this Agreement, it is expressly understood that the Board has reserved unto itself the exclusive right and authority to exercise discretion concerning the plan.

SECTION II – The Board's Obligations and Financial Arrangements Pertaining to the Services to be Performed by Crossroads.

2.1 The Board acknowledges that it bears all monetary responsibility for the payment of claims under the Plan and that Crossroads does not assume any financial responsibility whatsoever in connection with the payment of benefits arising out of claims made under the Plan. Under no circumstances shall Crossroads be called upon to or required to advance its own funds for the payment of benefits based upon claims under the Plan. Crossroads is not an insurer or underwriter of Plan liabilities or of the financial obligations of the Fund.

St. James, New York 11780

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117 Berg Court
Daytona Beach, FL 32124

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1500 Broadway, Suite 2300
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If either party desires to be notified at an address which is different from that set forth above, it shall provide at least 10 days advance notice of such changed address as provided in this Subsection. All notices shall be deemed received on the date set forth on the return receipt for the certified mail.

SECTION XIII – Agreement Counterparts.

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and said counterpart shall constitute but one of the same instruments.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed by their respective representatives and/or officers duly authorized to so act.

THE BOARD OF TRUSTEES OF THE ALLIED WELFARE FUND

By: _____
Union Trustee

By: _____
Employer Trustee

CROSSROADS HEALTHCARE MANAGEMENT LLC

By: _____
Michael DeBartolome
Managing Member

EXHIBIT A

ADMINISTRATIVE SERVICES

CROSSROADS HEALTHCARE MANGEMENT, LLC ("CHM") shall provide:

A. Third Party Administrator Claims Processing

1. Timely process all claims for all medical. dental, hospital, laboratory, diagnostic, drug benefits, as filed with CHM in accordance with the terms of the Plan provided all necessary documentation has been furnished.

2. Communicate with each claimant and service provider and obtain, where appropriate, additional documentation to the extent necessary to process claims.

3. Determine each individual claimant's eligibility for each filed claim for benefits filed in accordance with the terms of the Plan and procedures established by the Trustees.

4. Communicate in a timely manner to each claimant the payment or denial of each claim in detailed explanation of benefits which includes, among others, the amount of the claim to be paid, the deductible and co-payment, if any, the type of benefit paid, the right to appeal and the time limits and procedures for appealing any denial of a claim.

5. Issue checks on behalf of the Fund in a timely manner to covered persons or to such other entitled provider payee of that portion of amounts due under the Plan for each claim of a covered person that qualifies for payment under the terms of the Plan. With respect to each such claim, CHM shall furnish a detailed explanation of benefits, as set forth herein.

6. Verify and maintain individual records of eligibility including the coordination with other group coverage, verification of dependent status, existence of qualified medical child support orders and enrollment in institutions of higher learning

7. Coordinate with Fund staff for the administration of the program of benefits as required by COBRA.

8. Maintain individual records of claims for benefits and payment or denial of claims as appropriate under the terms of the Plan and in conformity with applicable legal record retention requirements.

9. Maintain an up-to-date database of reasonable and customary charges for the geographic areas serviced by the Plan in sufficient detail to ensure that charges beyond the limitations of the Plan are not included in the computation of benefit payments, and administer the Plan in accordance with accepted standards for reasonable and customary charges.

10. Track all deductible amounts, out of pocket expenses and annual or lifetime dollar service based maximums in accordance with Plan requirements.

11. Provide a monthly claims register of all paid claims in both check number and alphabetical order, in sufficient detail to permit orderly and proper reconciliation of each payment under the Plan.

12. Provide a monthly, quarterly and annual accounting of all claims, premiums, fees and other costs, if any, paid or coordinated by CHM on behalf of the Fund including details of date of service, date of claim, premium, fee or cost paid, and category of claim, premium, fee or cost payment in sufficient detail to permit analysis of claim and premium costs and all other fees and costs by category of service. Said accounting shall be provided by the 10th of the month following close of the month or quarter in question and by the 60th day following close of Plan Year.

13. CHM shall administer, on a timely basis, the State of New York and all other applicable uncompensated claim and other surcharges for covered services.

14. CHM shall be responsible for the preparation, distribution, and filing of all 1099 forms and other returns as required by laws with respect to all service providers paid on behalf of the Fund by CHM under the Benefit Plan.

15. Administer all enrollment requirements for new and existing members and their families. Distribute all appropriate forms, procedures, and any other written communications pertaining to the Fund including employee ID cards, claim forms, summary plan descriptions, and summaries of changes or modifications upon occurrence.

16. CHM shall, on a monthly basis, compute all appropriate insurance premiums and verify or compute any ancillary charges, such as printing expenses, and preparation of such for payment at the direction of the Fund and in accordance with contracts existing or established by the Fund.

B. Consulting Services

1. Recommend and design Fund and Plan structure for approval by the Trustees.

2. Recommend and develop amendments or revisions to the Plan as requested.

3. Assist in the preparation of all employee communications and disclosure materials and help to develop draft language for the summary plan description to be provided to all covered participants.

4. On an annual basis assist with actuarial analysis of cost projections and benefit liabilities, and claim reserves as appropriate, related to all Fund operations in the areas of benefits, insurance coverage and administrative fees, and during the life of the collective

bargaining Agreements that may be entered into by the Union(s), recommend contractual contribution rates designed to maintain the Plan on an actuarially sound and prudent basis.

5. Pursuant to the terms of the Plan, coordinate benefits with other plans.

6. Determine, for financial reporting purposes, the incurred but unreported claims and other benefit liabilities that are required to be disclosed on the Fund's financial statements as requested by the Fund's auditors.

C. Membership Services and Communications

1. Provide a dedicated customer service group.

2. Provide the Fund a toll free "800" number for the membership, dependent families and Fund providers.

3. Provide representation on request to attend membership meetings for the purpose of explaining all medical, dental, and other benefits.

4. Respond in timely and appropriate manner to all inquiries from employees, providers, claimants, other plan administrators, and insurance companies.

5. Assist in the enrollment of new Fund members and their families.

6. Process in timely fashion and in accordance with applicable law and regulations any and all written requests, issues or comments received from Covered Persons or any appeals of benefits denied and forward to the Fund all information in report format for review and decision by the Fund's Appeal Committee.

7. Finalize all amounts due and payable as a result of appeal approval, or explanation of denial, in accordance with the written instructions of the Fund.

8. Provide at least two representatives for employee benefit negotiations in all matters relating to medical, dental, and other insured or self-insured benefits.

D. Reporting, Contracting and Other Related Consulting Services

1. Provide to the Fund detailed management reports on a quarterly basis of all payments made by or on behalf of the Fund.

2. Prepare and present at each quarterly Trustee's meeting comprehensive benefits utilization reports.

3. Prepare, at the direction of the Fund, a formal agenda of CHM' s quarterly presentations for each meeting.

4. Prepare a monthly report of all appropriate insurance premiums and ancillary charges for payment at the direction of the Fund and in accordance with contracts existing or established by the Fund and an accounting each month and by quarter of all such premiums and ancillary charges paid on behalf of the Fund.

5. Provide all Form 5500 information and disclosure for the Fund including all in formation within CHM ' s knowledge or possession regarding information required to be reported on Schedule A or C of Form 5500 or as required by ERISA or such other schedules or disclosures as may be applicable to information with CHM's knowledge.

6. Assist the Fund's actuaries, attorneys, accountants, consultants and/or insurance carriers in preparation of any necessary federal or state returns, reports or disclosures.

7. Develop and present not less than once every two years, all actuarial forecasting relative to the ongoing administration of the Fund and the Plan.

8. Represent the Fund in related health care and insurance benefits meetings and discussions, as appropriate or as requested by the Trustees.

9. Develop and implement computer systems internally to maintain accurate, efficient, and timely reporting statistics.

10. Conduct comprehensive bidding as appropriate for network providers or other service providers including discount or PPO networks for pharmacy, medical, dental, mental health services, etc. and make recommendations to Fund Trustees for re-hiring and retention of same. Negotiate with providers for discount arrangements and prepare all contracts in connection there with subject to review by Fund Trustees and counsel. Monitor, on behalf of the Trustees, and report on the performance of contracted providers and make recommendations to Trustees for changes as appropriate. Provide additional information via industry networks as specified upon written request of the Fund.

11. Conduct competitive bidding and provide for contracted insurance services upon written request of the Fund.

E. Fund Office Administration and Compliance

MEMBER MASTER FILE

Crossroads shall maintain, manage and administer:

- All member master history database;
- Status changes, member master database including start and end dates; service break dates; other member separation matters and tracking;
- Dependent files and history database;
- Status changes, dependent master files database including eligibility dates; age qualification dates; school enrollment dates;
- Dependent documentation files and recordkeeping;
- Enrollments, new member hires and management of enrollment process.

EMPLOYER MASTER FILE

- All CBA contracts, contract file, rates;
- All former and current CBA employers by employer code;
- Employer contacts and communications.

FUND BILLING AND ACCOUNTING ASSISTANCE

- Monthly employer billing via check off system;
- Collection and deposit daily recordkeeping reconciliation;
- Cash applications;
- Collection tracking, reporting, employer intervention;
- Accounts receivable management, reporting, aged balance with delinquency reporting;
- Banking, bank interface, financial reporting;
- Accounting assistance, bookkeeping, check reconciliations;
- Insured benefits billing and administration.

COMPLIANCE ADMINISTRATION

- COBRA administration and management;
- HIPAA processes compliance;
- FMLA compliance, tracking;
- Other legal compliance including, but not limited to QMSCO, QDRO, as applicable.

F. Managed Care Services

In addition and as a complimenting service to traditional third party administration CHM maintains and applies a system of Health Plan Management. Typically referred to as managed care within the healthcare industry CHM health plan management is an integrated process of applied cost containment practices and procedures specific to Plan required healthcare delivery components.

Beyond traditional managed care definition, CHM's cost containment Managed Care Services ensure care excellence and accessibility; offer continuity of medical technology advancements; and yield favorable and measurable financial results for Fund and participant alike.

CHM will provide the following Managed Care services described in the Addendum attached to Exhibit A:

- Addendum 1: General Managed Care Services
- Addendum 2: Chiropractic and Podiatry
- Addendum 3: Claims Suspension Program
- Addendum 4: Dental Program
- Addendum 5: Hospital Inpatient Program
- Addendum 6: Outpatient Facilities Program
- Addendum 7: Physicians PPO Program
- Addendum 8: Pharmacy Benefits
- Addendum 9: Utilization Management/Utilization Review
- Addendum 10: Health Care Fraud and Abuse Special Investigative Unit
- Addendum 11: UCR, Medical Pricing Management
- Addendum 12: Reserve Development